

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 4 5 0 0	
										REG. NO.	
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>Leo</i>		MIDDLE <i>Xeo X. Andrysak</i>		3. DATE OF BIRTH MONTH DAY YEAR		4. RACE <i>White</i>		5. AGE IN YEARS (LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 78 YRS	
6. SEX <i>Male</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto., Md.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil County</i>		10. CITY OR TOWN OF DEATH <i>Perry Point</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Veterans' Admin. Medical Center</i>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i>		13b. COUNTY -----		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>714 South Conkling St. 21224</i>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Retired</i>	
14. FATHER'S NAME FIRST <i>Andrew</i>		MIDDLE <i>Andrysak</i>		15. MOTHER'S MAIDEN NAME FIRST <i>Catherine</i>						12b. KIND OF BUSINESS OR INDUSTRY <i>Lever Bros.</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>W.W. II</i>		17. INFORMANT <i>VAMC, Perry Point, Maryland</i>		ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Anoxia encephalopathy</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic heart disease</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from saw the deceased alive on above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> view the body after death.		22b. SIGNATURE <i>JOSEPH J. KIM</i>		22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH J. KIM, M.D.</i>		22e. ADDRESS <i>VAMC, Perry Point, Maryland</i>		22f. DATE SIGNED <i>2-24-83</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>2-28-83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>St. Stanislaus</i>		23d. LOCATION CITY OR TOWN <i>Baltimore City, Maryland</i>					
24. FUNERAL DIRECTOR NAME <i>Zeuler Funeral Home 901 S. Conkling St., Baltimore, Md.</i>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <i>FEB 28 1983</i>		REGISTRAR'S SIGNATURE <i>John J. Zeuler</i>					

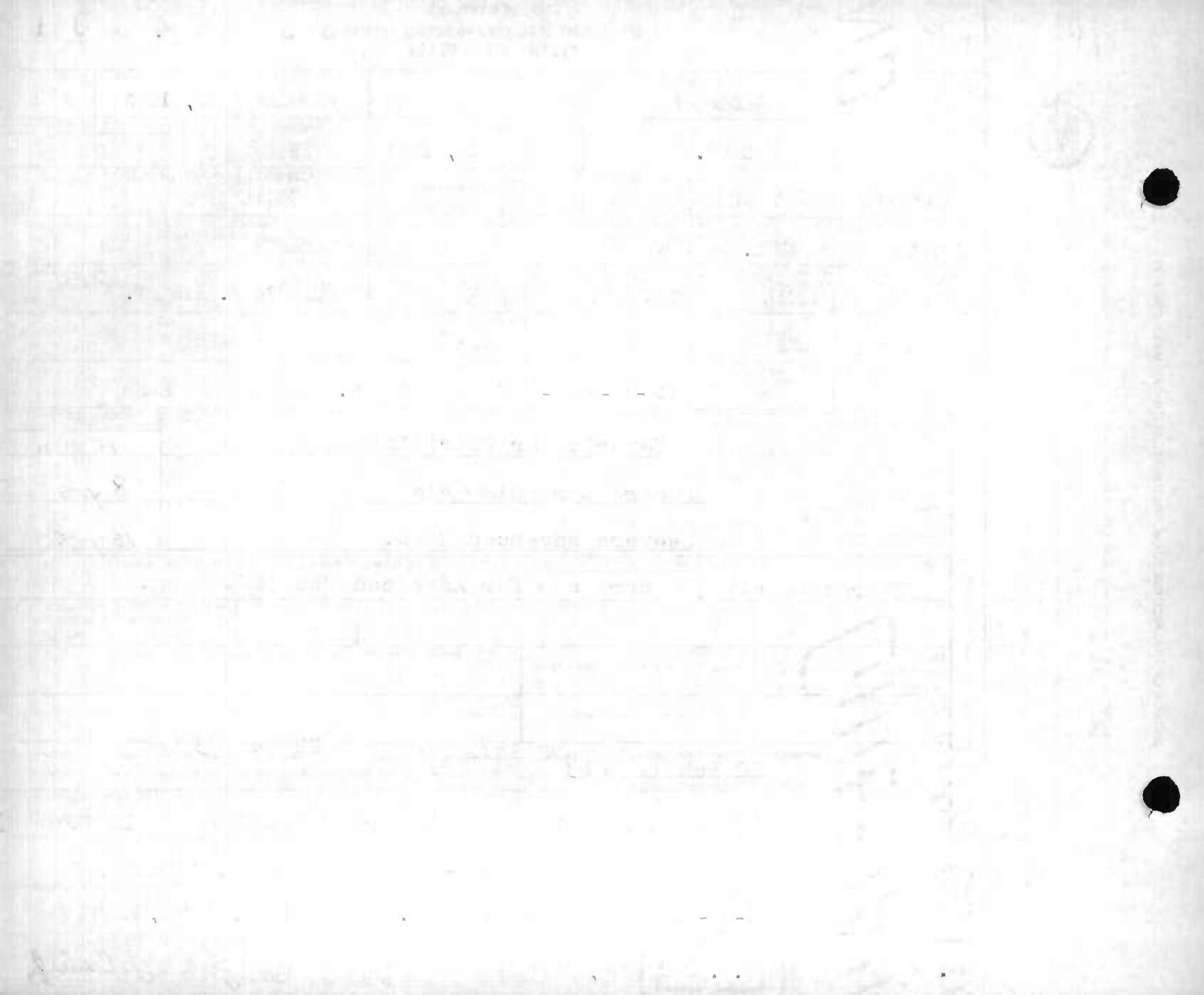


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, unless it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 0 4 5 0 1	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
MINA ALDERSON BOYD						FEBRUARY			22,	1983		5 a m	
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE CAUC.				JUNE 20, 1903			79			MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CECIL				
10. CITY OR TOWN OF DEATH CECILTON			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) E. MAIN ST			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER			12b. KIND OF BUSINESS OR INDUSTRY HOME				
13a. STATE MARYLAND			13c. CITY OR TOWN CECILTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS BOX 374 E.MAIN ST.			21913	
14. FATHER'S NAME ROBERT			FIRST LEE	MIDDLE	LAST ALDERSON	15. MOTHER'S MAIDEN NAME ELLA			16. MIDDLE WARREN			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 218-16-9906-A			17. INFORMANT EUGENE BOYD SR. HUSBAND			ADDRESS SAME				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min	
DUE TO, OR AS A CONSEQUENCE OF (b) sveere Cor pulmonale  8 yrs													
DUE TO, OR AS A CONSEQUENCE OF (c) Severe advanced COPD.  16 yrs.													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Thoracoplasty 40 years ago for Advanced Tbc left lung.													
19a. DATE OF OPERATION 9/9			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (he/she) attended the deceased from Aug 1975, 19, to 22 Feb 83, 19, that (I) (he/she) last saw the deceased alive on 22 Feb 83, and that in (my) (his/her) opinion death occurred on the date and hour and from the causes stated above, (I) (he/she) did not view the body after death.													
22b. SIGNATURE Wallace Obenshain, MD												DEGREE	
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												22c. DATE SIGNED 24 DFEB 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALLACE OBENSHAIN			22e. ADDRESS CECIL-KENT HEALTH CENTER, CECILTON, MD										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-25-83			23c. NAME OF CEMETERY OR CREMATORIAL CECILTON ZION CEM.			23d. LOCATION CECILTON, CECIL, MARYLAND				
24. FUNERAL DIRECTOR NAME EDW. FELLOWS & SON F.H. CECILTON, MARYLAND			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Mar 3 1983 John J. Coniff							
(VRA 15 (4))													



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner number must be noted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8304502				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
John C. Campbell						February 19, 1983						4:10 A.M.		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Cauc.		7-3-1904		78			MONTHS	YEARS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Sussex, Dela.			U.S.A.				Cecil Co.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Elkton			Union Hospital							Chr. Asmby Plant			Auto	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Delaware			New Castle		Newark					260 Elkton, Road				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST			
			Arthur		Campbell				Anna	Virginia	Rust			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)							17. INFORMANT			ADDRESS	
No			180-14-3824							Mary V. Campbell			Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CONGESTIVE HEART FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) SEVERE COPD														
DUE TO, OR AS A CONSEQUENCE OF (c) ARTHROSCLEROTIC CARDIOVASCULAR DIS.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
										YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-18-83 to 2-19-83, that (I) (we) last saw the deceased alive on 2-18-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Rolando Najera M.D.										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-22-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rolando Najera M.D.										22e. ADDRESS 105 E. Main St. - Elkton, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY				
Burial			2-23-1983		St Dennis Cemetery			Havertown, Dela. Cty., Pa.						
24. FUNERAL DIRECTOR NAME William J. Warwick			ADDRESS Newark, Dela.							25a. DATE REC'D. BY REGISTRAR FEB 24 1983		25b. REGISTRAR'S SIGNATURE John J. Coniglio		



ANNE GUTH

EXCELSIOR

MINNESOTA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83	04503			
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
NYLE			Vincent	COLLEDGE		2 - 7 - 83						7:53P M		
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male			White	MONTH	DAY	YEAR	44			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Pennsylvania			USA						Cecil Co.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Elkton			Union Hospital			Parts Manager			Truck Co.					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland			Cecil		Perryville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5 Whiteoak Drive		21903			
14. FATHER'S NAME			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME							
Grant			-		Colledge		Myrtle			Winters				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes			1957-60			Mrs. Carolyn R. Colledge, Perryville, Md.			21903					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a) <u>Act Myocardial Infarction</u> PART II. CONDITIONS WHICH CONTRIBUTED TO DEATH DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2-27</u> , 19 <u>82</u> , to <u>2-7-</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-6-</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Jayantilal K. Patel MD</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>2-8-83</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JAYANTILAL K. PATEL MD</u>			22e. ADDRESS <u>123 Singeney Ave, Elkton, MD 21921</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-10-83			23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill Memory Gardens, Salisbury, Maryland			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME <u>Ralph E. Hicks</u>			ADDRESS HICKS HOME FOR FUNERALS, ELKTON, MD. 21921			25a. DATE REC'D. BY REGISTRAR FEB 15 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>					

88 5-2-83

Acme-Cottage

88



88 88 1 100 100

100 100

100 hours	1000 hours	10000 hours	100000 hours
1000	10000	100000	1000000
10000	100000	1000000	10000000
100000	1000000	10000000	100000000
1000000	10000000	100000000	1000000000

waterproofed leather  
Hans J. Wegner

28 5-2 28 5-2 28 5-2

Exhibit X (10) Waterproofed leather  
Hans J. Wegner (in 1961) - Denmark

1000000000 100000000 1000000000 10000000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be called at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8304504						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
John V. CORUZZI						February 1, 1983						6:25 AM				
SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male			White	MONTH	DAY	YEAR	59 YRS.			MONTHS	DAYS	HOURS	MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			U.S.A.						Cecil County MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Perryville			VAMC, Perry Point, Md			Bar Owner			---							
13a. STATE			13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Maryland				Baltimore						2226 Eagle Street 21223						
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
Vincent					Coruzzi	FIRST Mary			LAST Distenfo							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR RATES)			17. INFORMANT			ADDRESS							
YES			WW II			217 14 6675			Ottavis Coruzzi 3915 Wilkens Ave, 21229							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:  4254 IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomiopathy																
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardio Vascular Disease																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									<input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug 13, 19 82, to Feb. 1, 19 83, that (I) (we) last saw the deceased alive on Feb. 1, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE A. Vento, M.D.			DEGREE						22c. DATE SIGNED 2/1/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. Vento MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/5/83			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY Maryland		STATE		
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Baltimore, Md. 21229			ADDRESS						25a. DATE REC'D. BY REGISTRAR FEB 2 1983			25b. REGISTRAR'S SIGNATURE John J. Cahill				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301 W. Preston Street, Baltimore, Maryland 21201.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 4 5 0 5

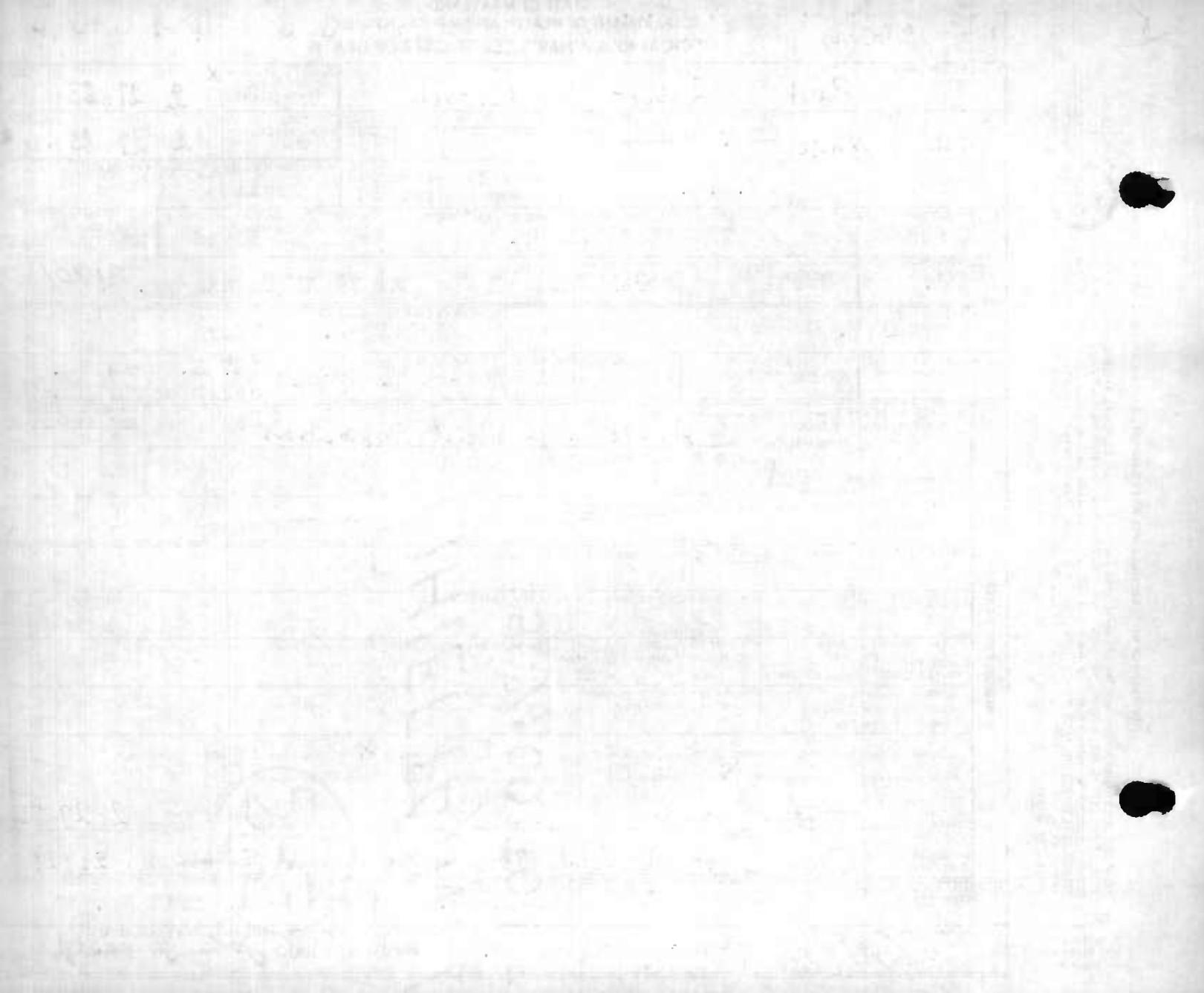
REG. NO.

I. DECEASED NAME (TYPE OR PRINT)			FIRST <b>CHESTER</b>	MIDDLE <b>R.</b>	LAST <b>CRAIG</b>	2a. DATE OF DEATH <b>FEBRUARY 9, 1983</b>	MONTH DAY YEAR	2b. HOUR <b>a.m.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>April</b> DAY <b>13</b> , YEAR <b>1910</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>			
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Coal Miner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Coal</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Cecil</b>		13c. CITY OR TOWN <b>Childs</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1363 Blue Ball Road 21916</b>		
14. FATHER'S NAME FIRST <b>Jason</b>		MIDDLE <b>-</b>		LAST <b>Craig</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b>		MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>235-12-7817</b>			17. INFORMANT <b>Jane L. Honaker, Childs, Md. 21916</b>		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocard Infarction</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCV.D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVI. PVI</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>12/7/82</b> to <b>2/9/83</b> , that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.										22c. DATE SIGNED <b>2-15-83</b>
22b. SIGNATURE <b>Sr. m. Hsu</b>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jui Chih Hsu</b>		22e. ADDRESS <b>223 West Main St., Elkton, Md. 21921</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2-11-83</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Elkton Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Elkton, Maryland 21921</b>		COUNTY	STATE
24. FUNERAL DIRECTOR <b>Hicks E. Hicks</b>		ADDRESS <b>HICKS HOME FOR FUNERALS, ELKTON, MD. 21921</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 22 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conard</b>			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- DATE 3/4/83 JAB		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 0 4 5 0 6						
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- MATED		MONTH	DAY	YEAR	2b. HOUR				
Paul			Robert				Crouch		<input checked="" type="checkbox"/>		2	27	1983	M				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH	DAY	YEAR	2d. HOUR	
Male		White		Feb. 27 1983		53 yrs.						2		27	1983	A 6.10 M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?										9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.										Cecil					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
North East			79 Algonquin Dr.										Self Employed			Funeral Dir.		
13a. STATE			13b. COUNTY		14. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
Md.			Cecil		North East				79 Algonquin Dr. 21901									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST															
Paul E. Crouch			Nellie D. Lankford															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		127 S. Main St.											
Yes Korea			217-24-8626		Robert T. Crouch		North East, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF  4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?					
													YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																		
ACTUAL SIGNATURE <i>Juan C. Gonzalez-Vitale, M.D.</i>			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER										DATE SIGNED 2-27-83					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS Union Hospital, Elkton, MD 21921															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 3-3-83		23c. NAME OF CEMETERY OR CREMATORIAL North East Meth.		23d. LOCATION TOWNSHIP		23e. COUNTY CITY STATE									
Burial									North East Cecil Md.									
24. FUNERAL DIRECTOR NAME <i>Robert Crouch</i>			ADDRESS North East, Md.										25a. DATE REC'D. BY REGISTRAR MAR 4 1983			25b. REGISTRAR'S SIGNATURE <i>John J. Coughlin</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be consulted at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 4 5 0 7			
										REG. NO.			
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			MILDRED M.			ELLIOTT			FEBRUARY 7, 1983			A.M.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS	
Female			White			May 12, 1925			57 YRS.			MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.	
West Virginia			USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Elkton			Union Hospital			Homemaker			-				
13a STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Cecil			Elkton			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			300 Park Circle 21921	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Henry - Epling			Bessie - Bias										
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS				
No			220-24-5978			Mrs. Henrietta Boyce, Elkton, Md. 21921							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Failure</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ASHD</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>area</i> , 19 <i>83</i> , to <i>2/7</i> , 19 <i>83</i> , that (we) lost saw the deceased alive on <i>area</i> , 19 <i>83</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.													
22b. SIGNATURE <i>[Signature]</i> DEGREE										22c. DATE SIGNED 2-8-83			
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Joseph G. Lanzi, M.D.</i>			22e. ADDRESS <i>721 Bridge Street, Elkton, Md. 21921</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>2-9-83</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Stonewall Memory Gardens, Manassas, Virginia</i>			23d. LOCATION CITY OR TOWN <i>Manassas, Virginia</i>				
24. FUNERAL DIRECTOR NAME <i>Donald S. Hicks</i> ADDRESS <i>HICKS HOME for FUNERALS, ELKTON, MD. 21921</i>			25a. DATE REC'D. BY REGISTRAR <i>FEB 15 1983</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

1891-5-10-15

110115

110115

50

1891-5-10-15

50

50



1100

1100

1100

1100

1100

1100

1891-5-10-15

1100

1100

1100

1100

1100

1100

1100

1891-5-10-15

1100

1100

1100

1891-5-10-15

1100

1100

1100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 2f is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 3 0 4 5 0 8	
						REG. NO.	
1 - FOR STATE REGISTRAR	FIRST <b>MABEL</b>	MIDDLE <b>E.</b>	LAST <b>GRAY</b>	2a. DATE OF DEATH <b>FEBRUARY 24, 1983</b>	MONTH DAY YEAR	2b. HOUR <b>M</b>	
1. DECEASED NAME (TYPE OR PRINT)	3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>January</b> DAY <b>14</b> YEAR <b>1905</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b>	IF UNDER 1 YEAR MONTHS <b>YRS.</b>	IF UNDER 24 HRS HOURS <b>MIN.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b>	10. CITY OR TOWN OF DEATH <b>Elkton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>MD.</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Cecil</b>	13c. CITY OR TOWN <b>Elkton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Winding Brook Gardens</b>	21921		
14. FATHER'S NAME FIRST <b>Ruben</b>	MIDDLE <b>-</b>	LAST <b>Rhoades</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Ida</b>	MIDDLE <b>-</b>	LAST <b>Butler</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>262-36-3412A</b>	17. INFORMANT <b>Ruben C. Sanders, Earleville, Md. 21919</b>	ADDRESS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> <b>4292</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO, OR AS A CONSEQUENCE OF</b> (b) <b>LOW BLOOD PRESSURE HEART FAILURE</b> { DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> .						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>2-20</b> , 19 <b>83</b> to <b>2-24</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>2-24</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						22c. DATE SIGNED <b>2/28/83</b>	
22b. SIGNATURE <b>Rolando A. Najera, M.D.</b>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Rolando A. Najera, M.D.</b>	22e. ADDRESS <b>105 E. Main Street, Elkton, Md. 21921</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>2-28-83</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Bethel Cemetery</b>	23d. LOCATION CITY OR TOWN <b>Chesapeake City, Md. 21915</b>	COUNTY	STATE		
24. FUNERAL DIRECTOR <b>Hicks E. Hicks</b>	ADDRESS <b>HICKS HOME for FUNERALS, ELKTON, MD. 21921</b>	25a. DATE REC'D. BY REGISTRAR <b>MAR 9 1983</b>	25b. REGISTRAR'S SIGNATURE <b>John G. Chase</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached from us as the burial-transit permit. Then please remove carbon paper, pages 1 and 2, and attach to the burial permit. It should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other trauma, enter the medical examiner's name.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8304509
				REG. NO.
1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR
I. DECEASED NAME (TYPE OR PRINT)		ROBERT SIMPSON HUMPHREY		February 9, 1983 10:17pm
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1923
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 59 yrs. yrs. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil County MD.		
10. CITY OR TOWN OF DEATH Perry Point		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center Perry Point, MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer
12b. KIND OF BUSINESS OR INDUSTRY -----		13a. STATE Virginia		13c. CITY OR TOWN Fairfax Springfield
14. FATHER'S NAME FIRST J. MIDDLE P. LAST Humphrey		15. MOTHER'S MAIDEN NAME Ethel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 6/25/40 245-12-3153		13e. STREET ADDRESS -----
17. INFORMANT V.A.M.C., Perry Point, Maryland 21902		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4519 Cardio respiratory arrest - sudden DOUE TO, OR AS A CONSEQUENCE OF (b) Massive pulmonary embolus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF Thrombophlebitis		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from Jan 25, 1983, to Feb 9, 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Feb 9, 1983, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (had) view the body after death.				
22b. SIGNATURE K. H. HUEBNER		22c. DEGREE M.D.		22d. DATE SIGNED 2-10-83
22e. ADDRESS VAMC, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Feb. 15, 1983		23c. NAME OF CEMETERY OR CREMATORIAL Rogers & Breece Crematorium Fayetteville Cumberland
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Perryville, Md.		25a. DATE REC'D. BY REGISTRAR FEB 23 1983		25b. REGISTRAR'S SIGNATURE John J. Coniglio N.C.

70

Georg Schmid  
Büro für  
Technik und  
Wirtschaft  
Gesellschaft für  
Technik und  
Wirtschaft

22-07-2



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8304510						
										REG. NO.						
1 - FOR STATE REGISTRAR			2a DATE OF DEATH							MONTH	DAY	YEAR	2b HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST		Feb. 2, 1983			5:00 AM			
Odell William Jones																
3 SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Male			White			MONTH Nov. DAY 16 YEAR 1914			69			MONTHS		DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.				
N.C.			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Cecil			MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Elkton			Union Hosp.			LaboerRet.			Tree Trimer			21918				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Md.			Cecil			Conowingo			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			37 New Valley Rd.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
FIRST Lester			MIDDLE H.			LAST Jones			FIRST Bessie			MIDDLE Irwin			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 240-16-0335			17. INFORMANT Odell W. Jones Jr. ( Same as Deceased ) Son			ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 RESPIRATORY FAILURE										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) ADVANCED LUNG CANCER																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART I OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Yash. A. Patel			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 2/16/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Y. A. Patel			22e. ADDRESS Union Hosp. Elkton, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Feb. 5, 1983			23c. NAME OF CEMETERY OR CREMATORIAL West Nottingham Cem.			23d. LOCATION CITY OR TOWN Colora			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME John McMullen Dea.			ADDRESS Rising Sun, Md.			25a. DATE REC'D. BY REGISTRAR FEB 8 1983			25b. REGISTRAR'S SIGNATURE John J. Cawich							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please rejoin by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 4 5 1 1					
										REG. NO.					
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
		George						Kulis JR		2 10 83					8:35 P.M.
3 SEX		4 RACE		5 DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.			
M		W		MONTH 3		DAY 17		YEAR 09		73		YEARS		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		Cecil Co MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY									
Elkton		Union		Pet Beef Boner		Food									
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS		21915					
MD		CECIL		CHESAPEAKE				55 RANDALIA RD							
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		2A P					
GEORGE				KUSIS		MARY									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO.		17 INFORMANT		ADDRESS		CHESAPEAKE CITY MD							
NO		166-07-4816		MARGARET KULIS											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any										Act Respiratory Failure					
(b) Chronic Obstructive Pulm. Disease															
(c) Pneumonia															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY	STATE						
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 2/10/83, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE Jayantilal K. Patel		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 2/11/83									
22d PHYSICIAN'S NAME (TYPE OR PRINT) JAYANTILAL K. PATEL MD		22e ADDRESS 123 Singerly Ave, Elkton, MD 21931													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-14-83		23c NAME OF CEMETERY OR CREMATORIAL ST. ROSE OF LIMA CHESAPEAKE CITY CECIL		23d LOCATION CITY OR TOWN		COUNTY	STATE						
24 FUNERAL DIRECTOR R. T. FOARD FUNERAL HOME		ADDRESS		25a. DATE REC'D. BY REGISTRAR FEB 18 1983		25b. REGISTRAR'S SIGNATURE G. J. Canfield									

88-81834

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04512

REG. NO.

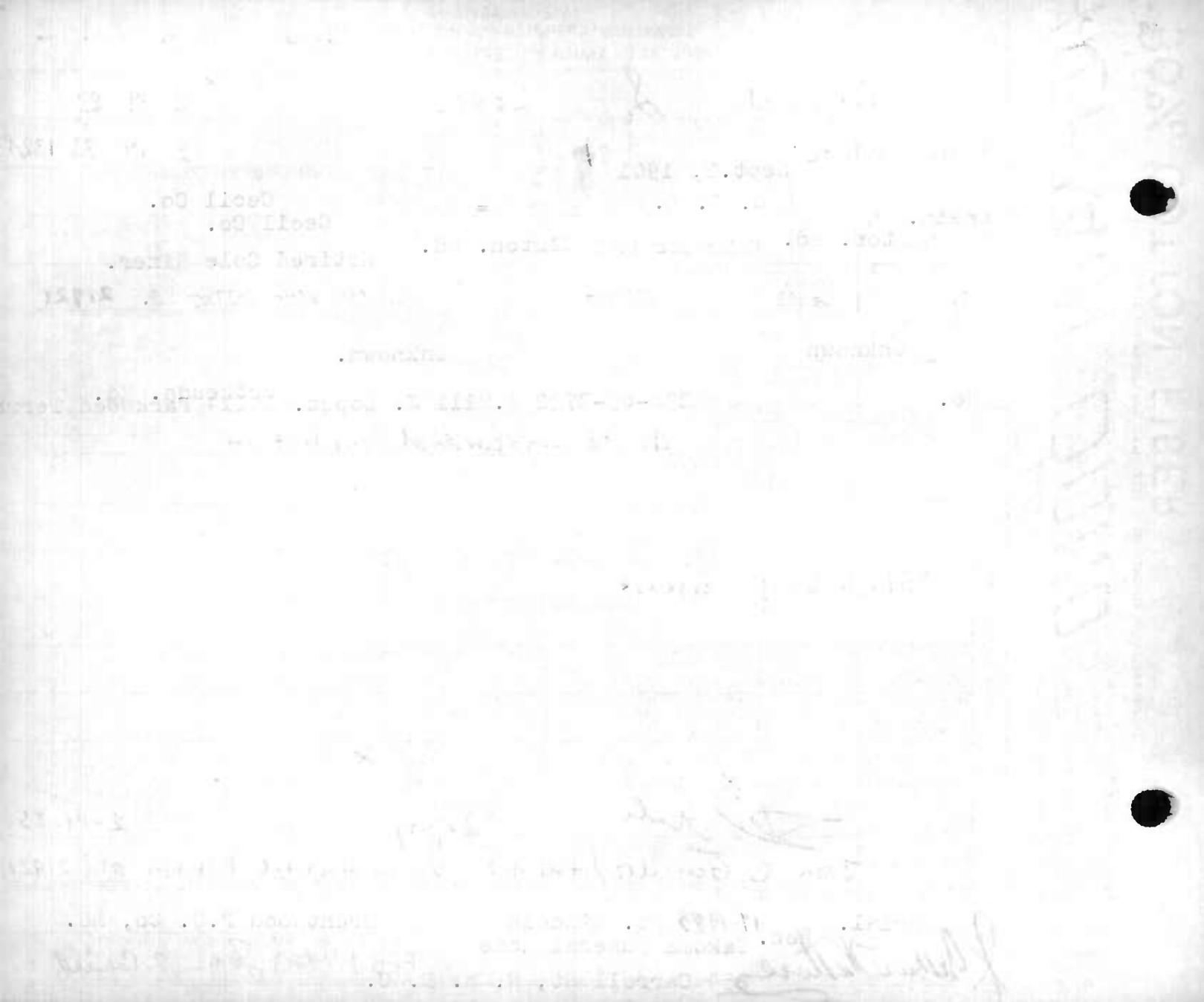
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR			
Raymond S. Lopez							<input checked="" type="checkbox"/>	9	14	83				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.									
Male	White	Sept. 2 1901	81	MONTHS DAYS	HOURS MIN.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. PLACE OF DEATH U. S. A.			8	MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co.							
Spotsylvania	Elkton. Md.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	Elkton. Md.		12a. USA OPERATION FOR MOST OF WORKING LIFE	12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							Retired Coal Miner.							
13a. STATE MD	13b. COUNTY Cecil	13c. CITY OR TOWN Elkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 200 Pine Valley Rd. 21921										
14. FATHER'S NAME FIRST Unknown	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Unknown.	MIDDLE	LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.	16b. SOCIAL SECURITY NO. 236-05-3732			17. INFORMANT Al. Bill J. Lopez.	ADDRESS Bethesda, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  "Black Lung" disease														
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?							
19b. DATE OF OPERATION	19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						20. AUTOPSY?							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. LOCATION STREET CITY OR TOWN COUNTY STATE												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>S. Lopez</i>							TITLE (SPECIFY) M.D.		DATE SIGNED 2-14-83					
EXAMINER'S NAME (TYPE OR PRINT) Juan C Gonzalez-Vitale MD							ADDRESS Union Hospital, Elkton, Md. 21921							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial. Feb. 17-1983	23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln	23d. LOCATION CITY OR TOWN Brentwood P.G. Co., Md.	COUNTY		STATE								
24. FUNERAL DIRECTOR Name <i>Robert Peter</i>	ADDRESS	25a. DATE REC'D. BY REGISTRAR FEB 17 1983	25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>											
54 Carroll St., N. W. D. C.														

BIMONTHLY OF VITAL RECORDS, 281 W. PRESTON ST., BALTIMORE. MR. 21281

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF OFFICIAL RECORDS, 201 WES顿 STREET, BALTIMORE, MARYLAND, BY 21ST DAY OF BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M2/80



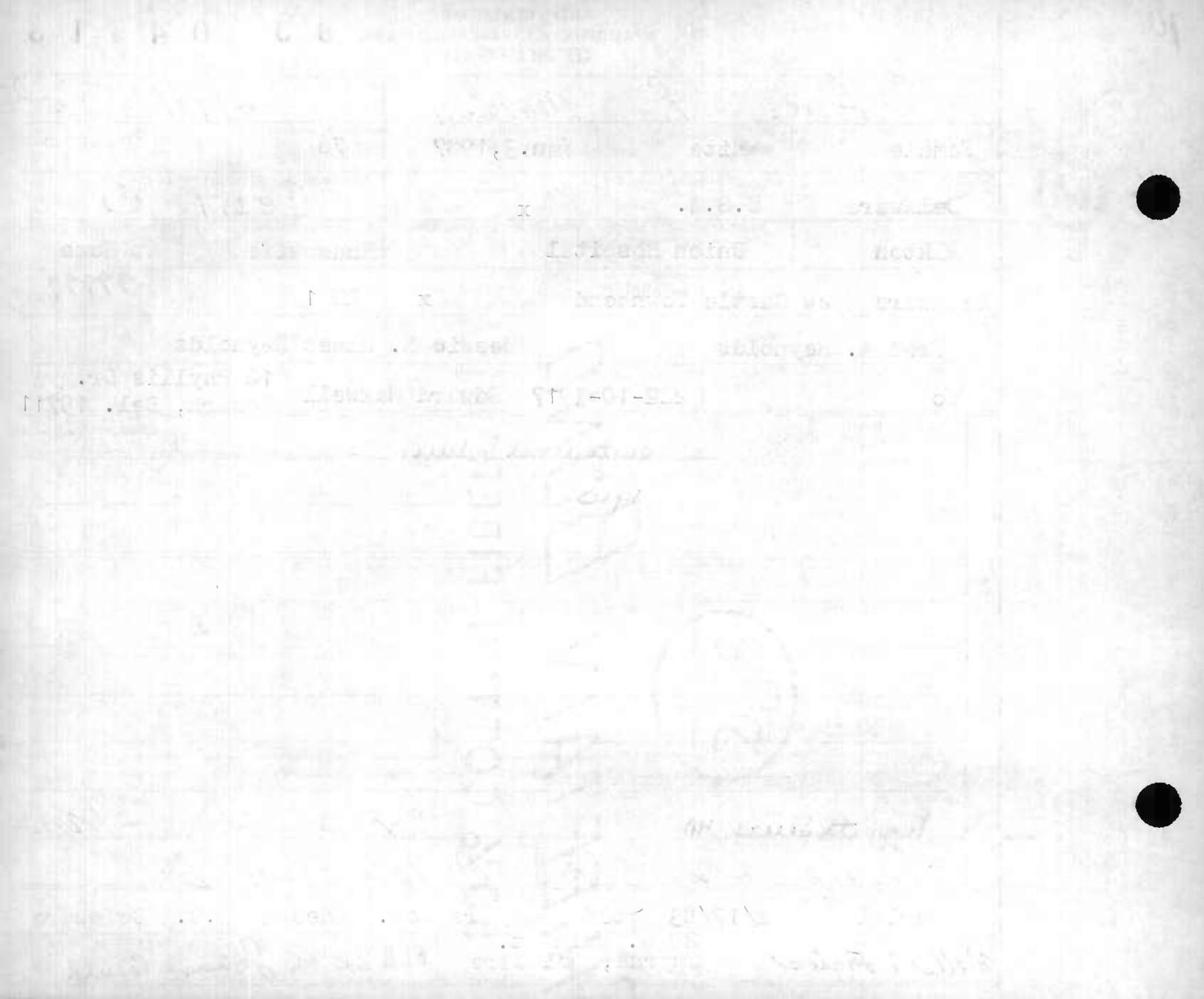
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8304513				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			LAST <i>Alice R. Maxwell</i>			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
3. SEX Female			4. RACE White			5. DATE OF BIRTH JUN. 3, 1907			6. AGE (IN YEARS LAST BIRTHDAY) 76					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.					
10. CITY OR TOWN OF DEATH Elkton			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY At Home					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware										13b. COUNTY New Castle	13c. CITY OR TOWN Townsend	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS RD 1	99999
14. FATHER'S NAME FIRST MIDDLE LAST Fred A. Reynolds			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie E. Humes Reynolds											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 222-10-3917			17. INFORMANT Edward Maxwell			ADDRESS 18 Phyllis Dr. Newark, Del. 19711					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute renal failure.</i> 0389 DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>sepsis</i> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 2/18/83				
22b. SIGNATURE <i>Lenneth Lewis, M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lenneth Lewis, M.D.</i>			22e. ADDRESS <i>Middle town, Del.</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/17/83			23c. NAME OF CEMETERY OR CREMATORIAL Old Drawyers Cem.			23d. LOCATION CITY OR TOWN Odessa N.C. COUNTY Delaware STATE					
24. FUNERAL DIRECTOR <i>Wells A. Faries</i>			29 S. Main St. Smyrna, Delaware			25a. DATE REC'D. BY REGISTRAR FEB 22 1983			25b. REGISTRAR'S SIGNATURE <i>John DeCarlo</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 3 0 4 5 1 4				
												REG. NO. 117				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST VARD			MIDDLE MINTON			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 11:20pm	
												February 7, 1983				
3. SEX <b>Male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 9, 1895</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE COUNTRY <b>Kentucky</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil</b> MD.							
10. CITY OR TOWN OF DEATH <b>Perry Point, Md.</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>VA Medical Center</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Railroad Worker</b>			12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>			13c. CITY OR TOWN <b>Silver Spring</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <b>974 Shore Road</b>			<b>20901</b>	
14. FATHER'S NAME FIRST <b>Unknown</b>			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b>			MIDDLE			LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. (IF UNKNOWN, GIVE WAR OR DATES) <b>718-14-3001</b>			17. INFORMANT <b>V.A.M.C. Records, Perry Point, Maryland</b>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b>																
4241 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b>				
{ DUE TO, OR AS A CONSEQUENCE OF (c) <b>aortic stenosis</b>												<b>Arteriosclerotic cardio vascular disease w/</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 14, 1982</b> to <b>February 7, 1983</b> , <b>XXXXXXXXXX</b> XXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, if (we) (did) (did not) view the body after death.												22c. DATE SIGNED <b>2-8-83</b>				
22b. SIGNATURE <i>J. R. Garcia, M.D.</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>										
27e. ADDRESS <b>VAMC, Perry Point, Md.</b>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Feb. 12, 1983</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Bruner Cemetery</b>			23d. LOCATION CITY OR TOWN <b>London, Laurel Co, Kentucky</b>			COUNTY	STATE			
24. MEDICAL DIRECTOR <b>Lee A. Patterson &amp; Son</b>			ADDRESS <b>Perryville, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>FEB 15 1983</b>			25b. REGISTRAR'S SIGNATURE <i>J. R. Garcia</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be palled.

## MEDICAL CERTIFICATION

1 - STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 8304515			
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>ARTHUR</i>	MIDDLE <i>NMT</i>	LAST <i>Newsome</i>	2a. DATE OF DEATH MONTH <i>Feb. 19 83</i>				DAY YEAR <i>12 P.M.</i>	2b. HOUR <i>12 P.M.</i>					
3. SEX Male		4. RACE White		5. DATE OF BIRTH <i>9-4-1916</i>	6. AGE (IN YEARS LAST BIRTHDAY) YEAR <i>66</i>	IF UNDER 1 YEAR MONTHS <i>YRS.</i>		IF UNDER 24 HRS HOURS <i>MIN.</i>							
7a. BIRTHPLACE COUNTRY <i>Kentucky</i>		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Cecil</i>				MD.						
10. CITY OR TOWN OF DEATH <i>Elkton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A HOSPITAL FACILITY, GIVE STREET ADDRESS) <i>Union Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK OR TRADE OF WORKER) <i>housekeeping</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Govt.</i>					
13a. STATE <i>Md.</i>		13b. COUNTY <i>Cecil</i>	CITY OR TOWN <i>North East</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>65 Charbon Dr.</i>		21901						
14. FATHER'S NAME FIRST <i>Harrison</i>		MIDDLE <i>Newsome</i>	LAST <i>AST</i>	15. MOTHER'S MAIDEN NAME FIRST <i>Victoria</i>				MIDDLE <i>Newsome</i>	LAST <i>Newsome</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>401-18-9535</i>		17. INFORMANT ADDRESS <i>Corenner S. Newsome North East, Md.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour</i>							
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>myocardial infarction</i>								4 weeks							
{ (c) <i>Arteriosclerotic heart disease</i>								24 years.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Chronic obstructive pulmonary disease</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>6/1/81</i> to <i>2/19/83</i> , that (I) (we) lost saw the deceased alive on <i>21/19 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.								22c. DATE SIGNED <i>2/19/83</i>							
22b. SIGNATURE <i>Edgar E. Folk III</i>		22c. DEGREE <i>MD.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Edgar E. Folk III, M.D.</i>		22e. ADDRESS <i>Union Hospital, Elkton, Md. 21901</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <i>2-22-83</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>New Bridge Baptist</i>		23d. LOCATION CITY OR TOWN <i>Rising Sun Cecil Md.</i>		COUNTY		STATE					
24. FUNERAL DIRECTOR NAME <i>Robert A. Cawley</i>		ADDRESS <i>North East, Md.</i>				25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE <i>FEB 24 1983 John J. Cawley</i>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do my be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

8 3 0 4 5 1 6

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			HENRY	CLAY	PEAKER	February 13, 1983				11:55am	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
MALE			BLACK	MAY	22	1915	67	YRS.	MONTHS	DAYS	IF UNDER 24 HRS
7c. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND			U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			CECIL		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Perry Point, Md.			VA Medical Center			DOG GROOMER			SHOW DOGS		
13a. STATE MARYLAND			13b. COUNTY HARFORD			13c. CITY OR TOWN JOPPA			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
									13e. STREET ADDRESS 2024 SINGER Road 21085		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS	
LLOYD			TIMOTHY	PEAKER	JULIA			LEVENIA	DORSEY	2024 SINGER Road LAURA V. WALLACE JOPPA, MD. 21085	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO. (NAME OF WAR OR DATES) YES WWII KOR.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			214-10-0263			LAURA V. WALLACE JOPPA, MD. 21085					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Massive gastrointestinal hemorrhage					
5324			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost			DUE TO, OR AS A CONSEQUENCE OF (b) Bleeding duodenal "peptic" ulcer					
						DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 13, 1983, to Feb. 13, 1983, XXXXXXXXX XXXXXXXXXXXXXX, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
									2-14-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS								
S. GOLDGRABEN, M.B.			VA Medical Center, Perry Point, Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN		23e. COUNTY STATE		
BURIAL		FEB. 18, '83		MT. ZION METH. CEM.			JOPPA		HARFORD MARYLAND		
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REG'D. & SIGNED				
Howard McComas III Funeral Home, Abingdon, Md.					FEB 18 1983						

10:32:17

221 01 ground

10:32:17

VAL

Y

4D

10:32:17 McClosie III (mcclosie, 19) 10:32:17  
bit, (mcclosie, 19) 10:32:17

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health and Mental Hygiene prior to burial or removal.

— 3 —

**MEDICAL CERTIFICATION**

1 - FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3	0 4 5 1			
					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>John</i>	MIDDLE <i>H.</i>	LAST <i>Prest</i>	20. DATE OF DEATH MONTH <i>2/10/83</i>		YEAR <i>1983</i>	2b. HOUR <i>255 PM</i>			
3. SEX <b>Male</b>		4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <i>9-1-1912</i> YEAR		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Jenkintown, Pa Penna. USA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Penna. USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co MD.</b>					
10. CITY OR TOWN OF DEATH <b>Elkton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret. duPont Co.</b>						12b. KIND OF BUSINESS OR INDUSTRY <b>Mfg.</b>	
13a. STATE <b>Delaware</b>		13b. COUNTY <b>New Castle</b>	13c. CITY OR TOWN <b>Bear</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>389 Country Drive</b>		99999			
14. FATHER'S NAME FIRST <b>Harry</b>		MIDDLE <b>B.</b>	LAST <b>Prest</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Grace</b>		MIDDLE	LAST <b>Smith</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>153-01-5161</b>		17. INFORMANT <b>Grace A. Prest</b>		ADDRESS <b>Same</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>COPD</b>		4960		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bronchitis pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) <b>Severe COPD</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-4</b> , 19 <b>83</b> , to <b>2-10</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>2-10-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Roland Majera MD</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>2/10/83</i>					
22d. PHYSICIAN'S NAME, TYPE OR PRINT <i>Roland Majera MD</i>		22e. ADDRESS <i>EIKTON, Md 219-1</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE — <b>2-11-1983</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Silverbrook Crematory</b>		23d. LOCATION CITY OR TOWN <b>Wilmington, N.C. Delaware</b>		23e. DATE REC'D. BY REGISTRAR <b>FEB 15 1983</b>		23f. REGISTRAR'S SIGNATURE <i>John J. Conner</i>	
24. FUNERAL DIRECTOR NAME <i>William J. Warwick</i>		ADDRESS <i>Newark, Dela.</i>									

February

1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the medical examiner with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item 18c G577 3/17/83 dad

STATE OF MARYLAND

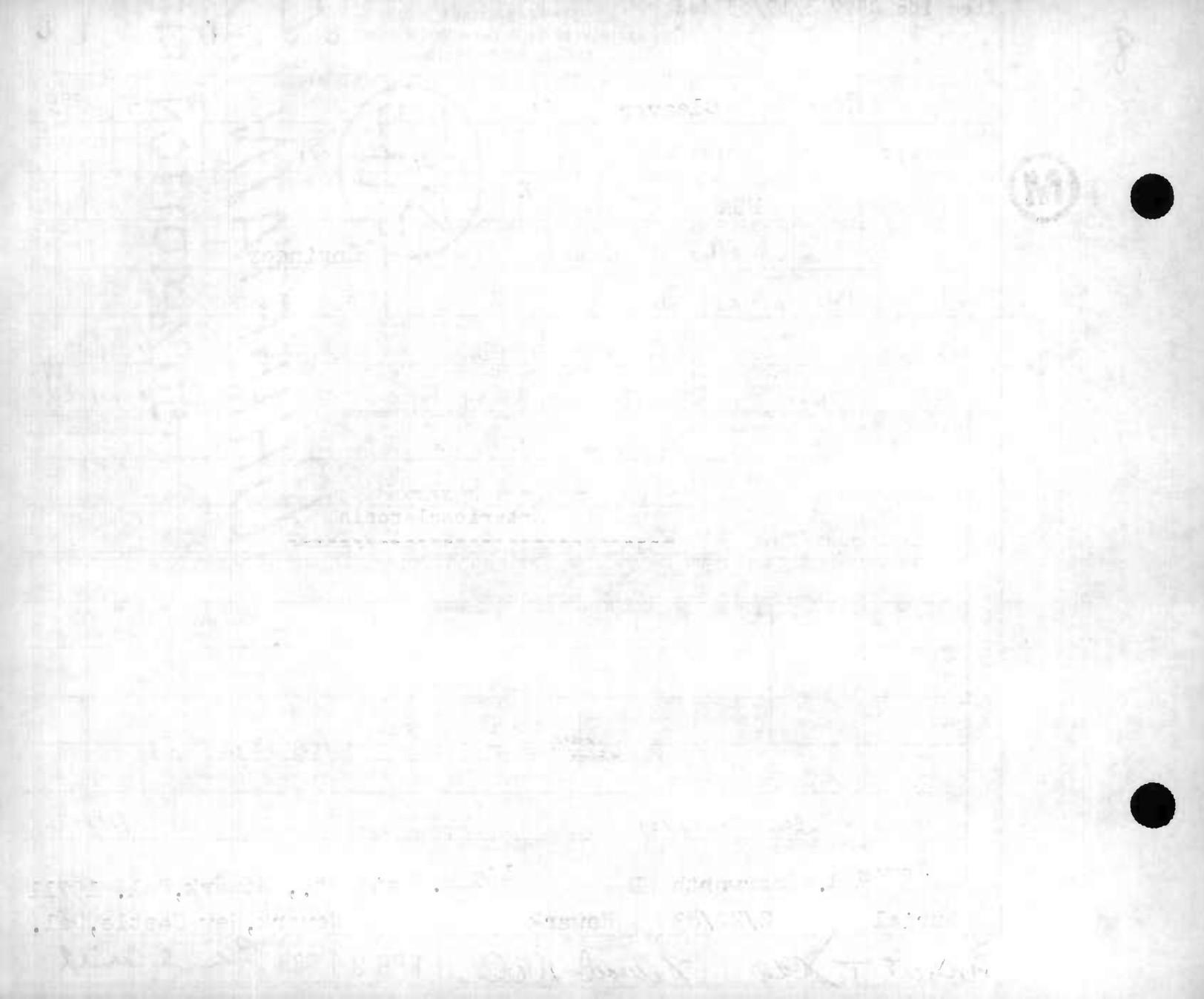
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 0 4 5 1 8

1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <b>GEORGE</b>	MIDDLE <b>Cleaver</b>	LAST <b>PRICE</b>	2a DATE OF DEATH MONTH DAY YEAR <b>2 18 83</b>	2b HOUR <b>1035 A.M.</b>
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>09 16 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CECIL MD</b>	
10. CITY OR TOWN OF DEATH <b>EKTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LAWRENCEWOOD NURSING CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Del.</b>		13b. COUNTY <b>Newcastle</b>	13c. CITY OR TOWN <b>Newark</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>260 EKTON Rd. 99999</b>		
14. FATHER'S NAME FIRST <b>George</b>		MIDDLE <b>C</b>	LAST <b>PRICE</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Ella</b>	MIDDLE <b>Virginia</b>	LAST <b>SUAN</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>222-18-5170A</b>		17. INFORMANT <b>Mary Price</b>	ADDRESS <b>260 EKTON Rd Newark Del 19711</b>		
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
<b>4379</b> Conditions, if any, which gave rise to immediate cause 18a, stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebrovascular disease</b>					
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II) <b>Aug 9th 82</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Aug 9th 82</b>		21f. LOCATION STREET <b>9th</b>	CITY OR TOWN <b>82</b>	COUNTY <b>Feb 18 1983</b>	STATE <b>19 83</b>
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 9th 82</b> to <b>Feb 18 1983</b> , that (I) (we) last saw the deceased alive on <b>2-9-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>James R. Dearworth</b>		DEGREE		ATTENDING PHYSICIAN	MEDICAL DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>2/18/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Dearworth MD</b>		22e. ADDRESS <b>167 W. Main St. Newark, Del. 19711</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>2/22/83</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Newark</b>	23d. LOCATION CITY OR TOWN <b>Newark, New Castle, Del.</b>			
24. FUNERAL DIRECTOR <b>Robert T. Jones</b>		ADDRESS <b>Newark, Del.</b>		25a. DATE REC'D. BY REGISTRAR <b>FEB 24 1983</b>			
REGISTRAR'S SIGNATURE <b>John J. Canfield</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of all such events.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8304519				
											REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	26 HOUR				
MILDRED E PROCTOR						2 15 83						2:10 P.M.				
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>OCTOBER 9, 1910</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	IF UNDER 24 HRS. HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Cecil Co</b>			MD.				
10. CITY OR TOWN OF DEATH <b>Elkton</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Union Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeping - Union Hospital</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Union Hospital</b>							
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Cecil</b>			13c. CITY OR TOWN <b>Elkton</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>230 West Main Street 21921</b>				
14. FATHER'S NAME FIRST <b>Hugh</b>			MIDDLE <b>Stanley</b>			LAST <b>Proctor</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b>			MIDDLE <b>Elizabeth</b>			LAST <b>Connolly</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>215-24-7056</b>			17. INFORMANT <b>Mr. Joseph R. Proctor, Elkton, Md. 21921</b>			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Act Renal Failure</b> <b>1830</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Status Post Op La Ovary w/ Metastasis -</b>																
DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a I certify that (I) (this hospital) attended the deceased from <b>2/15/80</b> , 19, to <b>2/15/83</b> , 19, that (I) (we) last saw the deceased alive on <b>2/15/83</b> , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Jayant Patel M.D.</b>			22c. DEGREE <b>M.D.</b>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <b>2/16/83</b>							
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <b>123 SINGERLY AVE ELKTON MD JAYANTILAL K PATEL M.D.</b>			22g. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>2-18-83</b>			23c. NAME OF CEMETERY OR CREMATORIAL <b>Elkton Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Elkton</b>			COUNTY	STATE			
24. FUNERAL DIRECTOR <b>Ralph E. Hicks</b>			ADDRESS <b>HICKS HOME for FUNERALS, ELKTON, MD. 21921</b>			25. DATE REC'D. BY REGISTRAR, REGISTRATION NO.			FEB 22 1983							

51

Ward 4

atins

pines

K

as

clay features



Indicated point - geological

Indicated point

rocks

150' from rock face OLS

rocks

rocks

basalts

shallow - sand

shallow

shallow

shallow

shallow

150' above rock face OLS - 500-AS-512

shallow - sand

shallow - sand

shallow - sand

X

shallow

shallow - sand

shallow - sand

shallow - sand

150' below rock face

shallow - sand

shallow

shallow

XO  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be identified on page 4.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8304520				
										REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2/1/83							130 P.M.	
Erwin F. Ralston														
3. SEX			4. RACE			5. DATE OF BIRTH MONTH Sept. 19 YEAR 1929			6. AGE (IN YEARS LAST BIRTHDAY) 53			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Male			White			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co MD					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			10b. KIND OF BUSINESS OR INDUSTRY		
75 Pa.			USA						Tool Room Mgr.			Textiles		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b. STREET ADDRESS					
Elkton			Union Hospital			13a. STATE MA. 13b. COUNTY Cecil			13c. CITY OR TOWN North East			21901 766 Hances Point Rd.		
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
NO						Elmer F. Ralston			Hanna L. Cummings					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO UNKNOWN			16b. SOCIAL SECURITY NO. 216-24-9031			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF ACUTE MYOCARDIAL INFARCTION (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 HOURS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 2-1-1983 to 2-1-1983, that (I) (was) (was not) last saw the deceased alive on 2-1-1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did not) view the body after death.														
22b. SIGNATURE Ehsanur Rahman			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 2-2-83					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EHSANUR RAHMAN														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-6-83			23c. NAME OF CEMETERY OR CREMATORIAL Rose Bank			23d. LOCATION CITY OR TOWN Rising Sun COUNTY Cecil STATE Md.					
24. FUNERAL DIRECTOR NAME Paul A. Conch			ADDRESS North East, Md.			25a. DATE REC'D. BY REGISTRAR FEB 7 1983 John J. Conch			25b. REGISTRATION NUMBER					

M

2012-0102-2A2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 4 5 2 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
			HALUS	L.	REYNOLDS, SR.	FEBRUARY 28, 1983						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Male		White		January 23, 1902		81 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Delaware		USA				Cecil						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Elkton		Union Hospital				Mail Carrier & Guard/Service			US Postal Almart Store			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Cecil		Elkton					113 Church Street 21921			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST	
Harvey		J.		Reynolds		Margaret			-		Fulton	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)				17. INFORMANT			ADDRESS			
Yes		219-05-9442				Mrs. Mary L. Reynolds, Elkton, Md. 21921						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRONCHOPNEUMONIA</u>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>SEVERE COPD ; ASCVD</u>												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 2-20, 1983, to 2-28, 1983, that (I) (we) last saw the deceased alive on 2-24, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Rolando A. Najera</u> DEGREE												
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED 3-2-83												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				22f. ADDRESS						
Rolando A. Najera, M.D.		105 E. Main Street, Elkton, Md. 21921										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		3-3-83		Bethel Cemetery		Chesapeake City, Md. 21915						
24. FUNERAL DIRECTOR NAME <u>John E. Hicks</u> ADDRESS												
HICKS HOME for FUNERALS, ELKTON, MD. 21921 25a. DATE REC'D. BY REGISTRAR ON REGISTRAR'S SIGNATURE MAR 9 1983 <u>John E. Hicks</u>												

1801-05-1987

5001-05-1987

021-05-

1987

05-1987

1801-05-1987  
5001-05-1987  
021-05-1987

1801-05-1987

05-1987

05-1987

05-1987

05-1987

05-1987

05-1987

1801-05-1987  
5001-05-1987  
021-05-1987

05-1987

1801-05-1987

5001-05-1987

021-05-1987

1801-05-1987

5001-05-1987

021-05-1987

1801-05-1987  
5001-05-1987  
021-05-1987

1801-05-1987  
5001-05-1987  
021-05-1987

1801-05-1987  
5001-05-1987  
021-05-1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the medical examiner, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 4 5 2 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
VALLEY					RICE	FEBRUARY 14, 1983			2:15A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
M		B		1	9	97	86 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
MD		USA							Cecil MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Perry Point		V A MEDICAL CENTER PERRY POINT, MD.		Cement Finisher		Gout.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
MD.		Harford		Bel Air				2317 Churchville Road			
14. FATHER'S NAME		FIRST	MIDDLE	15. MOTHER'S MAIDEN NAME							
		William	Rice	Laura							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
yes		9-1-18/12-13-18 212 14 0567		Helen Rice		Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 1850											
DUE TO, OR AS A CONSEQUENCE OF (b) RESPIRATORY ARREST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF PROSTATE WITH METASTASES											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOVEMBER 29, 19 82 to FEBRUARY 14, 19 83, that (I) (we) last saw the deceased alive on FEBRUARY 14, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 2-14-83					
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		VA MEDICAL CENTER PERRY POINT, MD							
P. JACQUES JEAN-PIERRE											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. COUNTY			
Burial		2/17/83		Clarks U M		Bel Air		Harford			
24. FUNERAL DIRECTOR NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR		25e. REGISTRAR'S SIGNATURE					
Arnold Beard Funeral Home, Havre de Grace, Md.				FEB 22 1983		John & Carol					

2145 5001.41.000000

2145

2145

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000

2145 5001.41.000000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 04523						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Tander (m) Seaton</i>									<i>2/26/83</i>						<i>1040 AM</i>	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH FEBRUARY DAY 28, 1908			74			MONTHS	YEARS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
<i>80 Texas</i>			USA									<i>Cecil Co</i>				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
<i>Elkton</i>			<i>Union Hospital</i>			<i>Finisher - Metal Products</i>										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
<i>Maryland</i>			<i>Cecil</i>			<i>North East</i>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<i>500 Lakeside Drive 21901</i>				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
<i>Robert</i>			<i>- Seaton</i>			<i>Hattie</i>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			<i>464-16-2377</i>			<i>Mrs. Lucille J. Seaton, North East, Md. 21901</i>										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
<i>4100 CARDIOPULMONIC SHOCK</i>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
(b) <i>ACUTE MYOCARDIAL INFARCTION</i>																
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <i>RECENT GASTROINTESTINAL BLEEDING.</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from <i>2/26/1983</i> , to <i>2/26/1983</i> , that (I) (we) lost the deceased alive on <i>2/26/1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																
22b. SIGNATURE <i>Ehsanur Rahman</i>										DEGREE	ATTENDING PHYSICIAN	<input checked="" type="checkbox"/> DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>EHSANUR RAHMAN</i>										22e. ADDRESS <i>2102 DRUMMOND PLAZA NEWARK, DE, 19711</i>			<i>2/28/83</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>3-3-1983</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Glenwood Memorial Gardens, Broomall, Pa.</i>			23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial																
24. FUNERAL DIRECTOR <i>Hicks E. Hicks</i>			ADDRESS <i>HICKS HOME for FUNERALS, ELKTON, MD. 21921</i>			25a. DATE REC'D. BY REGISTRAR <i>MAR 9 1983</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>							

卷之三

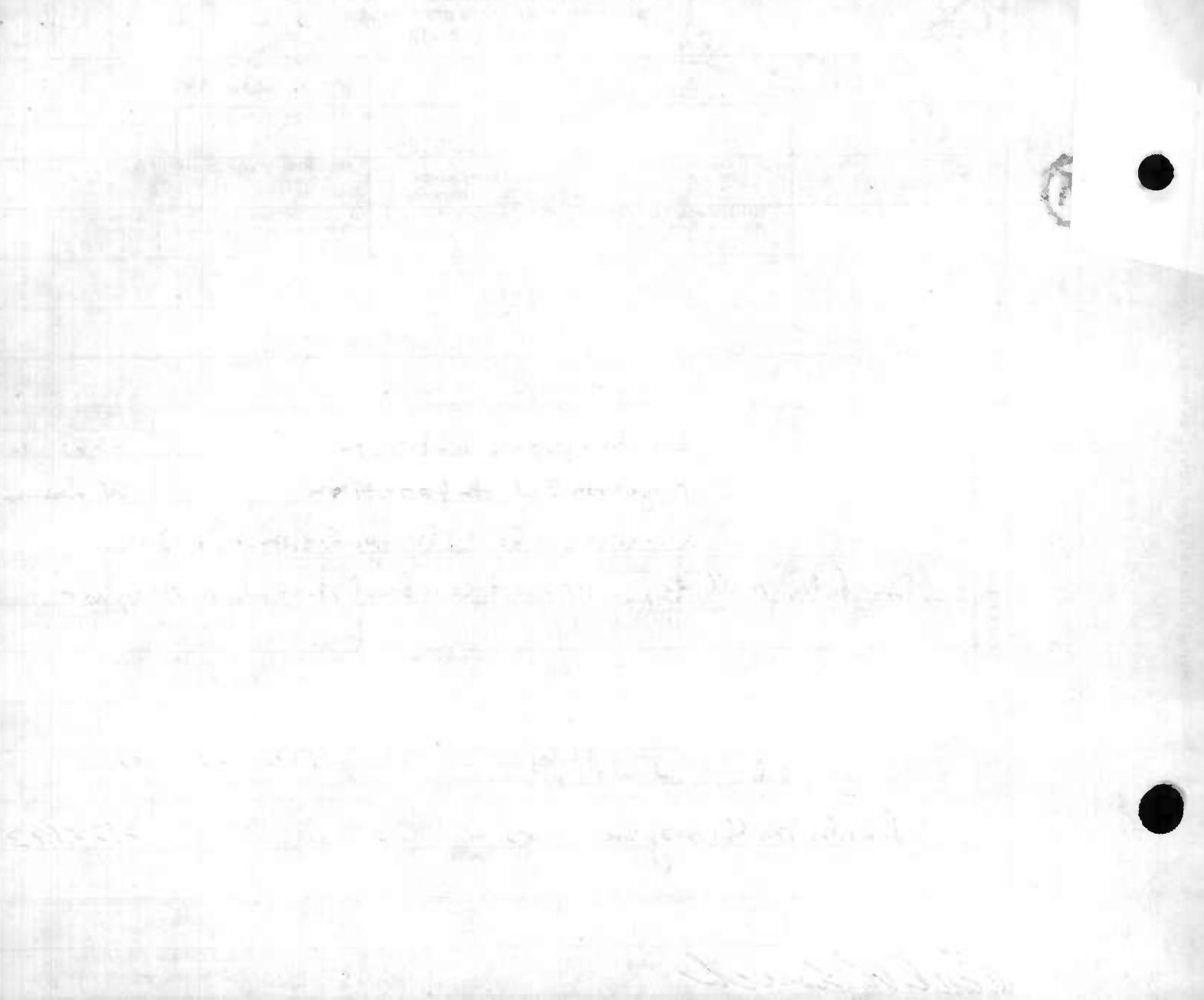
4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8304524							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Irene R. Shivery						Feb. 23, 1983						6:04 P.M.					
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White		Month Day Year June 18, 1909			73 YRS.			MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Mass.			USA						Cecil								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Elkton			Union Hospital			Housewife			Home								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Md.			Cecil			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14 Church St.			21901					
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST								
Arthur			Reid		Bertha Kenworthy												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
NO			220-05-0883			Charles H. Shivery			North East, Md.								
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs. 00</u>							
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Myocardial infarction</u>										<u>48 hours</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic cardiovascular Disease</u>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <u>Diabetes mellitus. Recent cerebral hemorrhage. Alcohol</u>																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 16, 1983</u> to <u>Feb 23, 1983</u> , that (I) (we) last saw the deceased alive on <u>Feb 23, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <u>Joseph M. Hargan, M.D.</u>										22c. DATE SIGNED <u>2/28/83</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			2-26-83			St. Mary Anne's			North East			Cecil		Md.			
24. FUNERAL DIRECTOR NAME <u>Paul R. Gough</u>			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
			North East, Md.			MAR 1 - 1983			<u>John J. Lahey</u>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	0	4	5	2	5
										REG. NO.						
1 - FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
		STANLEY			H.	SIEGEL		February 1, 1983						3:16pm M		
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White			July 22, 1922			60			MONTHS	DAYS	HOURS	MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Wash., D.C.		USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Cecil								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Perry Point, Md.		VA Medical Center			Elec. Tech.			Electrical			20879					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		9124 Bramble Bush Court						
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST			
Benjamin		Siegel						Tillie		Toby			Breiterman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			Miami, Fla.					
Yes		WW II			577-28-6370			Michelle Nachman; 15726 SW 112th Place								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4100 Cardiac arrest																
DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular fibrillation																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease w/coronary										thrombosis						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
					<input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from December 9, 1982, to February 1, 1983, XXXXXXXXX XXXXXXXXXXXXXXXXXXXXXXXXXXXX and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE										DEGREE						
LOUISE SULTAN, M.D.										ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>						
22c. DATE SIGNED										2-2-83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS						
LOUISE SULTAN, M.D.										VA Medical Center, Perry Point, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial		2-3-83			King David Mem. Gdn. Falls Church, Virginia											
24. FUNERAL DIRECTOR NAME		1170 Rockville Pike, Rockville, Md.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Goldberg-Danzensky Funeral Home, Bethesda, Md.		FEB 8 1983									John J. Canfield					

M

1000

Reported

1981

SAFETY

Major General Charles C. Feltz

5055-28-553

Category letter

Initial configuration identification  
Initial position  
Initial location

XXXXXX - 00 - 00000000 - 00

00000000000000000000000000000000

50-5-2

Major General Charles C. Feltz

00000000000000000000000000000000

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

## **TO HOSPITAL OR ATTENDING PHYSICIAN: The**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3 should be detached for use as a burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

DEPARTMENT OF HEALTH AND MENTAL HYGIENE										STATE OF MARYLAND				8 3 0 4 5 2 6			
CERTIFICATE OF DEATH										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH				MONTH	DAY	YEAR	2b. HOUR				
John C. SINGLEAR, JR.						/February 5, 1983							12:00 PM				
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Male			White	MONTH	DAY	YEAR	76				MONTHS	YEARS	HOURS	MIN.			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
Delaware			U.S.A.							Cecil County							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY				
Perry Point			VA MEDICAL CENTER						Plumber				Speakman Co.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										MD.							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Maryland			Cecil		Conowingo			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			984 Liberty Grove Rd., 21918						
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME							
John			MIDDLE	LAST	Sinclair, Sr.	D.	FIRST	MIDDLE	LAST	Irene	Sinex						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
Yes			1929-1953			Lura E. Sinclair			984 Liberty Grove Rd. Conowingo, Md. 21918								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) 1850 Conditions, if any, which gave rise to immediate cause (a), starting with the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b)							
										DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE					
22a. I certify that (I) <input checked="" type="checkbox"/> hospital attended the deceased from March 7, 1982, to February 5, 1983, that (I) (we) last saw the deceased alive on February 5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Rothbaum MD.</i>										DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 2/5/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
Kenneth ROTHBAUM, MD			VA MEDICAL CENTER, Perry Point, MD														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
Burial			Feb. 9, 1983			Gracelawn Memorial Park			New Castle		New Castle		Del.				
24. FUNERAL DIRECTOR <i>Patterson &amp; Son Funeral Home, Perryville, MD</i>			25a. DATE REC'D. BY REGISTRAR							25b. REGISTRAR							
			FEB 14 1983							<i>Jane C. Patterson</i>							

International Conference

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 0 4 5 2 7
					REG. NO.
1. FOR STATE REGISTRAR	FIRST Joseph	MIDDLE (nnn)	LAST STECKLER	2a. DATE OF DEATH February 12, 1983	MONTH DAY YEAR
1. DECEASED NAME (TYPE OR PRINT)	3. SEX male	4. RACE white	5. DATE OF BIRTH Jan 19, - 1892	6. AGE (IN YEARS LAST BIRTHDAY) 91	IF UNDER 1 YEAR MONTHS YRS
7a. BIRTHPLACE COUNTRY New York	7b. CITIZEN OF WHAT COUNTRY? USA	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BALTIMORE CITY OR COUNTY OF DEATH Cecil Co. MD.		
10 CITY OR TOWN OF DEATH Perryville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Perry Point VA Hosp.	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) conductor (ret)	12b. KIND OF BUSINESS OR INDUSTRY Railroad	13. STREET ADDRESS Box 529 (22520)	
13a. STATE VA	13b. CITY OR TOWN West Moreland Montross	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Box 529 (22520)		
14. FATHER'S NAME FIRST (UNKNOWN)	MIDDLE Steckler	15. MOTHER'S MAIDEN NAME FIRST (UNKNOWN)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes	16b. SOCIAL SECURITY NO. WW I 71616 1286	17. INFORMANT VAMC, Perry Point, Maryland	ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive hemo-pericardium</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rupture of heart</u> (c) <u></u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Carcinoma of prostate gland</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>8-3-</u> , 19 <u>82</u> , to <u>2-12-</u> , 19 <u>83</u> , the <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>2-12- 19 83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (I) (we) did <input checked="" type="checkbox"/> view the body after death.					
22b. SIGNATURE <u>JULIAN OCEOJO M.D.</u>	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 2-14-83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEOJO, M.D.	22e. ADDRESS VAMC, Perry Point, Md.				
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 15 Feb. 83	23c. NAME OF CEMETERY OR CREMATORIAL Carter Memorial	23d. LOCATION CITY OR TOWN	COUNTY	STATE
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie	25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE FEB 17 1983 <u>John J. Curran</u>		
FOR: Price Funeral Home, Montross, VA					

more than 1000

more than

more than

more than

less



more than

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Item 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be held within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 4 5 2 8				
										REG. NO.				
1 - STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST		2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
		Levi K. Stenroos								Feb. 8, 1983				3:29 PM
3 SEX		4 RACE		5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		MONTH June 7, 1907			75		MONTHS	DAYS	HOURS	MIN		
YRS.				8 CITIZEN OF WHAT COUNTRY?		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH				
		Oregon		U.S.A.						Cecil				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY				
Elkton		Union Hospital				Carpenter				Building				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a STATE	13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET ADDRESS								
Md..	Cecil	North East		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		111 Ontario Ct.		21901						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15 MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST					
		Gustav	A.	Stenroos			Edla		Eklund					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS								
No		079-01-2975		Agnes G. Stenroos		111 Ontario Ct.		North East, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4292 IMMEDIATE CAUSE (a) HEART FAILURE														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Chronic lung disease														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
22a I certify that (I) (this hospital) attended the deceased from _____ 19_____, To _____ 19_____, that (I) (we) lost saw the deceased alive on 2/7/83 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
22b SIGNATURE		22c. DATE SIGNED		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN				
Robert Gray		2/8/83		MD		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS		719 Bridge St. Elkton, Md. 21921										
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR						
Cremation		2-9-83		Cratin & Ferris		West Chester		COUNTY Chester Pa. STATE						
24. FUNERAL DIRECTOR NAME		ADDRESS		25e. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE								
John J. Conigliaro		North East, Md.		FEB 10 1983		John J. Conigliaro								

N



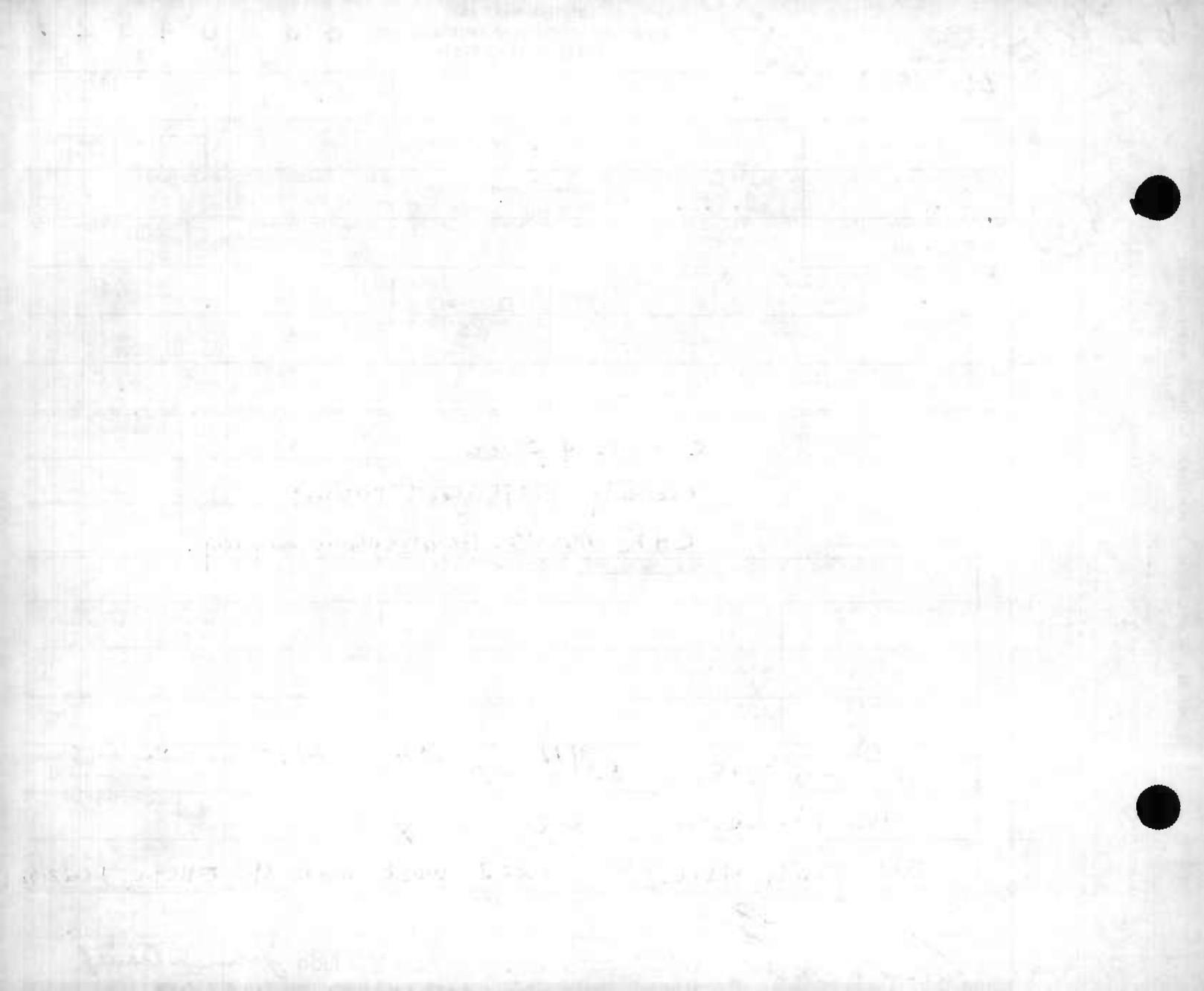
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 0 4 5 2 9	
										REG. NO.	
1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)					2. DATE OF DEATH					
	FIRST		MIDDLE	LAST	MONTH DAY YEAR					7b HOUR	
	Genia		S.	Taylor	Feb. 15, 1983					8:05 P.M.	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7c IF UNDER 1 YEAR		8d IF UNDER 24 HRS	
Female		White		Sept. 14, 1906		76		MONTHS DAYS		HOURS MIN	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7c CITIZEN OF WHAT COUNTRY?		8e MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.			
Va.		U.S.A.				Cecil					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT A NURSING FACILITY, GIVE STREET ADDRESS)					12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
Elkton		Union Hospital					Housewife		Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS		21901	
Md.		Cecil		North East				4 Harvey Ct.			
14 FATHER'S NAME		FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		ADDRESS			
		John		Salyers		Hilda		206 Lakeside Dr.			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT		North East, Md.				21901	
No		218-52-0375		Patsy Fields							
18 CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cirrhosis of Liver</u> 5718 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <u>Bladder espophageal varices</u> .											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>CMV. ASWD. Hepatosplenomegaly</u> .											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>9/17</u> 19 <u>82</u> to <u>2/15</u> 19 <u>83</u> , that (I) (we) last saw the deceased on <u>2/15</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.										22c DATE SIGNED	
22b. SIGNATURE <u>Jui chih Hsu.</u>		22c DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jui chih Hsu</u>		22e ADDRESS <u>223 west main st. Elkton, Md 21901</u>									
23a BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL			23d LOCATION CITY OR TOWN		COUNTY		STATE
Burial		2-19-83		Temple Hill Cem.			Castlemwood Russell		Va.		
24 FUNERAL DIRECTOR NAME		ADDRESS		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE					
		North East, Md.		FEB 22 1983		<u>John J. Carney</u>					

BP \_\_\_\_\_



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH FORM PM-3, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 21201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 0 4 5 3 0																		
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR															
Dean			Oscar			Thomas						2c. DATE PRONOUNCED DEAD			2d. HOUR															
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.							MONTH	DAY	YEAR	MONTH	DAY	YEAR													
Male	White	7 3 42	40 yrs.	MONTHS	DAYS	HOURS	MIN					9. BALTIMORE CITY OR COUNTY OF DEATH	Cecil County																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
Maryland		U.S.A.									Elkton			Union Hospital			Laborer			Henkels & McCoy, Inc.										
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Conowingo			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 227 Oakwood Road			14. FATHER'S NAME FIRST Dan			15. MOTHER'S MAIDEN NAME FIRST Grace			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 218-40-4328			17. INFORMANT Dan Thomas			422 Connelly Road Rising Sun, Maryland 21911		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) 4100		DUE TO, OR AS A CONSEQUENCE OF  Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF			(c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												Chronic alcoholism																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE															
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> ,			and in my opinion															
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Deputy			MEDICAL EXAMINER			DATE SIGNED 2/15/83																					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS			EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE															
Burial			Feb. 18, 1983			Brookview Cemetery			Rising Sun			Cecil			Maryland															
24. FUNERAL DIRECTOR NAME			Lee A. Patterson			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																					
Lee A. Patterson			Sonny Perryville, Maryland			MAR 2 1983																								

W



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	3	0	4	5	3	1
										REG. NO.						
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			NAZE E. WHERRY						February 20, 1983			3:45A M				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male			White			April 2, 1915			67 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			USA						Cecil							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (OWNER FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Perry Point			VA Medical Center Perry Point, MD			OWNER Benjamin & Wherry			Air Cond.							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Cecil			North East						21901 614 Mechanics Valley Road				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST													
Eri C. Wherry			Eva L. Thompson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
Yes WW 2			215-07-5074			Mrs. Pauline L. Wherry, North East, Md.			21901							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Neoplastic Metastatic Disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1850 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) <u>Cancer of Prostate</u>  (c) <u></u>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Nov 16</u> , 19 <u>82</u> , to <u>Feb 20</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb 20</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death.																
22b. SIGNATURE <u>Glendon Rayson</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED <u>2/20/83</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Glendon RAYSON MD			22e. ADDRESS VAMC, Perry Point, MD													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2-23-83			23c. NAME OF CEMETERY OR CREMATORIUM Friends Burial Ground			23d. LOCATION CITY OR TOWN Calvert, Maryland COUNTY STATE							
24. FUNERAL DIRECTOR <u>Ralph E. Hicks</u> Hicks Funeral Home, Elkton, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR FEB 28 1983			25b. REGISTRAR'S SIGNATURE <u>J. C. ... 2. Coarid</u>							

ALM 8 2011 007

5- 2011-007  
Date: 05-05-2011  
Time: 10:00 AM

Location: 2nd floor, 2nd room, 2nd door, 2nd window  
Date: 05-05-2011

View: 2nd floor, 2nd room, 2nd window, 2nd door, 2nd window

Angle: 10° 00' 00" 00' 00" 00' 00" 00' 00" 00' 00" 00' 00"

Date: 05-05-2011 Time: 10:00 AM

Object: object

Color: color

10' 00' 00" 00' 00" 00' 00" 00' 00" 00' 00" 00' 00"

points

00' 00' 00" 00' 00" 00' 00" 00' 00" 00' 00" 00' 00"

object: object 00' 00' 00" 00' 00" 00' 00" 00' 00" 00' 00" 00' 00"

object: object 00' 00' 00" 00' 00" 00' 00" 00' 00" 00' 00" 00' 00"

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the funeral director's office for 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 0 4 5 3 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
			Harry	A.	WILSON	February 15, 1983				5:30P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE STATE OR FOREIGN COUNTRY			
Male		Black		8	18	1888	91			YRS.			
7b. BIRTHPLACE STATE OR FOREIGN COUNTRY		7c. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			
Maryland		USA					Cecil			Perry Point, Md.			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA MEDICAL CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Janitor/Retired						12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		13f. ZIP CODE			
Maryland		Harford		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		601 Cornell Street		21001			
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			LAST				
UNK						UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
Yes WW-L			218 05 1496			Willie Avery, 608 Dorsey St., Aberdeen, Md.			21001				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.) PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Pneumonia												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) Severe anemia													
Conditions, if any, which gave rise to immediate cause 18a, stating the underlying cause lost.													
DUE TO, OR AS A CONSEQUENCE OF (c) Congestive heart failure													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 1, 1982, to February 15, 1983, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 2/15/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did (did not) view the body after death.												22c. DATE SIGNED 2-16-83	
22b. SIGNATURE Julian Ocejo, M.D.												DEGREE	
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>												22c. DATE SIGNED 2-16-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN OCEJO, M.D.												22e. ADDRESS VA Medical Center, Perry Point, Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE		
Burial		19 Feb. 83		Berkley Mem. Cemetery			Darlington		Harford		Md.		
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, Aberdeen, Md. 21001-3399												25e. DATE REC'D. BY REGISTRAR'S SIGNATURE FEB 22 1983 John J. Carroll	

www.english-test.net

initially in 1979 as part of the first phase of the project.

www.education.com

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 53045333

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Marcelle Alphonsine Young						<input type="checkbox"/> 2	13	1983	M		
3. SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) YRS.	7 IF UNDER 1 YR. MONTHS DAYS	8 IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
F	W	8 26 96	86			2 13 1983	11	A			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
FRANCE		U.S. A				CECIL					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
EARLEVILLE		LINWOOD AVE. CRYSTAL BEACH			Homemaker			Home			
13a. STATE MD		13b. COUNTY CECIL		13c. CITY OR TOWN EARLEVILLE	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS UNWOOD AVE 21919					
14. FATHER'S NAME FIRST ERNEST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST MARIE		MIDDLE	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 206-12-2595			17. INFORMANT	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4254 Congestive heart failure Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) Cardiomopathy DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
NO											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Deputy			DATE SIGNED 2-13-83						
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS			EXAMINER'S ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 2-14-83		23c. NAME OF CEMETERY OR CREMATORIAL SILVERBROOK CREM.		23d. LOCATION CITY OR TOWN WILMINGTON, DE		COUNTY	STATE		
24. FUNERAL DIRECTOR NAME EDW. Fellows & SON		ADDRESS Cecilton MD 21913		25a. DATE REC'D BY REGISTRAR FEB 18 1983		25b. REGISTRAR'S SIGNATURE					

60-1873